Study of Costs of Certain Mandated Benefits in Insurance Policies 2001

Office of the Commissioner of Insurance
October 2002

IP 37-2002

Introduction

The beginning of a new millenium has ushered in a new era of double-digit health care cost and health insurance premium increases. Near the end of the last decade, small employer health insurance rates started rising at increasing rates. Subsequently, large employers also began experiencing significant increases in health insurance costs. It quickly became apparent that health care inflation was about to become a major problem for employers, employees and policymakers alike.

Whenever there is an examination of health insurance costs, the subject of government mandated benefits in health insurance policies will arise. Government mandates are benefits an insurer is required by law to include in certain types of health insurance policies. The debate over mandates is usually framed in economic vs. public policy terms. Parties opposed to statutorily mandated benefits argue that health insurance mandates drive up the cost of employer-sponsored health care, potentially increasing the number of uninsured individuals. In addition, they point out state-imposed mandates create an uneven playing field with self-funded employer health benefit plans exempt from state mandate laws by ERISA. Proponents of health insurance mandates argue that the social benefits and need for the mandates outweigh the cost.

The primary focus of this report is an examination of the costs of selected health insurance mandates in Wisconsin for group health insurance and individual health insurance policies offered by the largest writers of health insurance in Wisconsin. The report does not attempt to draw conclusions regarding the mandates other than to provide comparisons with previous mandate studies. Also reviewed for comparison purposes is the level of benefits similar to the mandates provided by insurers who administer health plans for self-funded ERISA exempt employer health plans. This information reflects only a small portion of the self-funded plans and should not be considered to be a representative sample. In addition, the report identifies the cost of benefits for plans that provide benefits in excess of the amount required by the mandates. This report does not examine the merits of the mandates surveyed.

Background

Large increases in small employer health insurance premiums led to the creation of the Governor's Small Employer Health Insurance Task Force. The task force was charged with examining the conditions surrounding the small employer health insurance market and making recommendations to the Governor. To fulfill this charge, the task force requested information regarding mandated health insurance benefits in Wisconsin and other states.

After a brief examination of recent health insurance mandate studies conducted in Wisconsin and other states the task force determined that current data relating to Wisconsin's health insurance mandates was needed. The task force recommended to the Governor that a study of Wisconsin health insurance mandates be conducted. Previously, the Office of the Commissioner of Insurance (OCI) conducted studies of selected health insurance mandates for the years 1987-1990. Governor Scott McCallum accepted the task force's recommendations and directed OCI to conduct the survey.

Previous Mandate Study

In 1990, OCI reported on a three-year study of selected mandated benefits. The top ten writers of group health insurance in Wisconsin were asked to report on the business of calendar years of 1987, 1988 and 1989. All insurers surveyed were asked to report on their group health business. Additionally, those insurers that operate an administrative services only (ASO) business were asked to report separately for that business. ASO contracts are those in which an insurer contracts with a self-funded employer to collect premiums and pay claims without assuming any of the insurance risk which is retained and borne by the employer. These contracts are not subject to Wisconsin insurance law and therefore are not required to provide the mandated benefits. A copy of this survey detailing the mandates surveyed and results is available at the following website http://www.legis.state.wi.us/lc/2002studies/MHP/oci17_10II.pdf. The survey found that as a percent of premium the mandates selected had the following results:

	Average Cost as a % of Total Benefits		
Mandate	***1987***	***1988***	***1989***
Mental Health & AODA	5.08	4.82	4.77
Diabetes	0.14	0.18	0.13
Home Health	0.09	0.08	0.19
Skilled Nursing Care	0.13	0.08	0.16
Kidney	0.25	0.31	0.30
Chiropractic*	N/A	1.67	2.34
(*Chiropractic mandate became effective in 1988)			
Total	**5.70**	**7.13**	**7.89**

As the table below demonstrates, the survey also calculated the percentage of benefits paid in excess of the mandated benefit level.

	Average Excess Benefits as a % of Total Benefits		
Mandate	***1987***	***1988***	***1989***
Mental Health & AODA	1.03	0.82	1.74
Diabetes	0.00	0.00	0.00
Home Health	0.01	0.03	0.03
Skilled Nursing Care	0.03	0.03	0.02
Kidney	0.04	0.06	0.03
Total	**2.68**	**0.95**	**1.81**

Those insurers who operate an ASO business reported their "mandated" costs as follows:

ASO Benefit	***Ave Cost as a % of Total Benefits 1987***	***1988***	***1989***
Mental Health & AODA	7.43	7.32	7.48
Diabetes	0.20	0.15	0.03
Home Health	0.10	0.12	0.30
Skilled Nursing Care	0.21	0.14	0.17
Kidney	0.24	0.64	0.34
Chiropractic	1.54	1.48	1.80
Total	**9.73**	**9.84**	**10.12**

Finally, the first report compared the cost of the selected mandates for group policies by insurers reporting on both their insured and ASO business. To make this comparison, the percent of mandated benefits was combined with the percent of excess benefits to create a total percentage and then compared to the percentage covered by ASO business. The results are as follows:

Average Percent Amounts Paid by Insured and Self-Insured Plans

Year	***Insured***	***ASO***
1987	9.12	9.73
1988	8.77	9.84
1989	8.50	10.12

In 1991 OCI conducted a follow-up survey for activity in the year 1990 and issued a report. The 1991 report differed from the earlier report in two respects. First, mammography was added to the list of mandates included in the survey. This mandate first became effective in 1990. Second, the mandates for diabetes, home health care, skilled nursing care and kidney disease treatment were eliminated from the survey. Data collected from 1987-1989 demonstrated that the costs of these mandates accounted for less than 1% of the total medical benefits paid in each of the years studied.

As in previous years, the top ten group health insurers were asked to report the costs of mandates and the costs of the total medical benefits paid. Insurers who administer employer self-funded benefit plans were asked to report on both their insured business and the self-funded health care benefit plans to provide a measure of the differences between those plans. In addition to mammography, the mandates highlighted in the 1991 report were mandates covering nervous and mental disorders and alcoholism and other drug abuse (AODA), and chiropractic services.

The results of the 1991 survey revealed:

Mandate	***Benefits as a % of Total Benefits-1990***	
	Group	***ASO***
Mental Health & AODA	4.60	9.59
Mental Health & AODA Excess Benefits	0.92	N/A
Total Mental Health & AODA	5.52	9.59
Chiropractic	1.70	1.53
Mammograms	0.35	0.26
Total	**7.57**	**11.38**

Methodology

For the 2001 Mandate Survey, OCI requested the Life and Disability Advisory Council to provide advice regarding selection of the mandates to survey. OCI suggested the survey include the mandates for Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse; Chiropractic Services; Diabetes; temporomandibular disorders (TMJ) ; and Child Immunizations. The basis for suggesting these five mandates was the Mental Health and Chiropractic mandates were previously shown to exceed one percent of total benefits paid; the TMJ and Child Immunization mandates were new mandates since the last study; and the Diabetes mandate was subject to current legislation. The Life and Disability Advisory Council accepted OCI's suggestion and recommended that all five mandates be surveyed.

OCI selected the top twenty insurers for both the group and individual health insurance market as ranked by market share. Insurers that no longer wrote new policies or wrote only limited coverage (such as long term care, disability income and accident-only policies) were eliminated.

Insurers were asked to provide a summary of cost data for the calendar year 2001 for the five mandates selected by the Life and Disability Advisory Council. Cost data included amounts paid to provide the benefit, the amount of total benefits paid and any amounts paid in excess of the benefits required by Wisconsin Statutes. Also, for Child Immunizations, insurers were asked to provide cost data on the additional benefits paid to comply with the statute for 2001, the first year that this statute was effective. If the insurer wrote both group and individual health insurance products, they were asked to aggregate the data into those two groups. Insurers were also asked to indicate the number of covered lives and the total premiums collected for group and individual products.

If an insurer acted as a third-party administrator for self-funded companies, they were asked to provide cost data only for those plans where at least one of the mandated benefits are included by the plan. Total benefit and premium data for plans where the company provides administrative services only were limited to only those plans where at least one mandated benefit or coverage was included.

During the course of the survey, a question was raised regarding the selection of specific codes for each mandate such as CPT, ICD-9, Revenue, HCPC and DRG codes in compiling the data. Because individual insurers applied various diagnostic codes for billing and informational purposes, OCI recommended that insurers in consultation with actuarial and other staff make the best estimation possible after evaluating the data and the statutes cited. If there were some reservations or uncertainties in the application of various diagnostic codes, insurers were instructed to note them by forwarding a narrative along with the completed survey.

The previous surveys conducted in 1990 and 1991 identified distinctions and reported results between HMO and traditional (Indemnity) plans. This survey does not make these distinctions given the concern expressed by the Small Employer Health Insurance Task Force was overall cost, not cost based on plan type.

Description of Mandates Surveyed

In order to understand what a specific mandate covers, it is critical to review the enabling statute and regulatory guidance. As an appendix to this report, the full statute and guidance is reproduced.

Chiropractors: Appendix A
Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse: Appendix B
Diabetes: Appendix C
TMJ: Appendix D
Child Immunizations: Appendix E

Results

OCI received responses from 21 group health insurers, including companies that have health insurance products sold by multiple subsidiaries, covering over 1.6 million covered lives. These group health insurers reported collecting $3.9 billion in total premiums while incurring $3.5 billion in benefit expenses. OCI received responses from 13 individual health writers covering over 130,000 lives. These individual health insurers reported $349 million in total premiums while incurring $287 million in benefit expenses. Of the insurers surveyed, 10 reported on their ASO business activity. Those with ASO activity reported over $1 billion in benefit payments covering in excess of 470,000 covered lives.

Nervous and Mental Disorders and Alcohol and Other Drug Abuse (MH/AODA)

Insurers were asked to present cost data regarding coverage for MH/AODA treatment. Insurers were asked to identify costs for Inpatient, Outpatient and Transitional treatment costs. Since this mandate does not apply to individual policies, insurers with individual plans were not required to report on any costs, but ASO plans were asked to report on the coverage in the plans they administer. The insurers were also asked to report on any benefits they pay in excess of the mandated amount.

Group health insurers reported $116 million in MH/AODA benefits paid, or 3.23% of total benefits paid and 2.94% of total premium collected. Benefit payments ranged from a low of

.23% of benefits paid and .28% of premium collected to 24.25% of benefit paid and 10.35% of premium collected, though most ranged from 3% to 5%. The insurers also reported paying $4 million in excess benefits. Not every group insurer reported that they paid excess benefits but those that did reported that those benefits ranged from a high of nearly one half of one percent of total benefits paid to insignificant amounts of .01% or less. Broken down, group insurers paid $18 million for inpatient costs, $62 million for outpatient treatment and $1.8 million for transitional treatment. Some insurers reported that they did not account for prescription drug costs by treatment type and merely accounted for them as MH/AODA costs. A number of insurers reported that they do not include prescription drug costs under the mandate when calculating benefit limits, due to internal procedures or technical concerns. If these costs had been included the amounts and percentages would be larger. OCI is unable to estimate what those additional costs would be or the effect on the survey results.

Insurers with ASO business reported $31.9 million in MH/AODA benefits paid, or 3.12% of total benefits paid. Benefit payments ranged from a low of .06% of benefits paid to 10.12% of benefit paid, though most ranged from 2.5% to 5%. The ASO administrators also reported paying $6.1 million in excess benefits. Not every group insurer reported that they paid excess benefits but those that did reported that those benefits ranged from a high of 3.52% of total benefits paid to .05%. Broken down, ASO business reported paid $8.2 million for inpatient costs, $19.3 million outpatient treatment and $238,000 for transitional treatment. Again, some ASO payers reported that they did not account for prescription drug costs by treatment type and merely accounted for them as MH/AODA costs.

	Average Cost as a % of Total Benefits		
Mandate	***Group***	***Individual***	***ASO***
Mental Health & AODA	3.23	N/A	3.12
Inpatient treatment	0.53	N/A	0.80
Outpatient treatment	0.09	N/A	1.89
Transitional Treatment	0.13	N/A	0.02

	Total Benefits		
Mandate	***Group***	***Individual***	***ASO***
Mental Health & AODA	$116,000,000	N/A	$31,900,000
Inpatient treatment	18,900,000	N/A	8,200,000
Outpatient treatment	62,300,000	N/A	19,300,000
Transitional Treatment	1,800,000	N/A	200,000

Mandate	Excess benefits paid Group	Individual	ASO
Mental Health & AODA	$4,440,000	N/A	$6,183,900
Inpatient treatment	1,195,000	N/A	1,360,200
Outpatient treatment	607,000	N/A	1,065,100
Transitional Treatment	98,000	N/A	11,500

Chiropractic Services

Group health insurers reported $44 million in benefits paid under the Chiropractic mandate, or 1.24% of total benefits paid and 1.13% of total premium collected (see table on page 9). Benefit payments ranged from a low of .03% of benefits paid and .04% of premium collected to 22.8% of benefit paid and 9.73% of premium collected, though most ranged from 1.5% to 3%. The insurers did not report any excess benefit payments.

Individual health insurers reported $1.8 million in benefits paid under the Chiropractic mandate, or .64% of total benefits paid and .52% of total premium collected. Benefit payments ranged from a low of .07% of benefits paid and .07% of premium collected to 2.14% of benefit paid and 1.88% of premium collected.

Insurers with ASO business reported $13.7 million in benefits paid under the Chiropractic mandate, or 1.35% of total benefits. Benefit payments ranged from a low of .31% of benefits paid up to 1.73% of benefit paid. The ASO administrators did not report any excess benefit payments for Chiropractic Services, as defined under the mandate.

Some insurers and administrators of ASO business reported that their chiropractic services benefits were contracted out to providers through contracts utilizing capitation arrangements, usually meaning that health plans pay a flat fee per member/per month to the provider. Insurers reported their captitation payments as costs. While those costs reflect the actual cost to the insurer or ASO plans, they do not reflect the actual utilization of the benefit.

Diabetes

Group health insurers reported $21.2 million in benefits paid under the Diabetic mandate, or .59% of total benefits paid and .54% of total premium collected (see table on page 9). Benefit payments ranged from a low of .04% of benefits paid and .02% of premium collected to 2.5% of benefit paid and 2.4% of premium collected.

Individual health insurers reported $1.2 million in benefits paid under the Diabetic mandate, or .44% of total benefits paid and .36% of total premium collected. Benefit payments ranged from a low of .003% of benefits paid and .003% of premium collected to .75% of benefit paid and .66% of premium collected. Individual health insurers did not report any payments in excess of the mandate.

Insurers with ASO business reported $2.2 million in benefits paid under the Diabetic mandate, or .22% of total benefits. Benefit payments ranged from a low of .04% of benefits paid up to .38% of benefit paid. The ASO administrators did not report any excess benefit payments for the Diabetes services, as defined under the mandate.

Child Immunizations

Group health insurers reported $14.5 million in benefits paid under the Child Immunization mandate, or .40% of total benefits paid and .37% of total premium collected (see table on page 9). Benefit payments ranged from a low of .04% of benefits paid and .03% of premium collected to 3.5% of benefit paid and 1.9% of premium collected.

Individual health insurers reported $293,000 in benefits paid under the Child Immunization mandate, or .01% of total benefits paid and .01% of total premium collected. Benefit payments ranged from a low of .002% of benefits paid and .002% of premium collected to .46% of benefit paid and .56% of premium collected. Some individual insurers reported excess benefit payments of $23,652.

Insurers with ASO business reported $5.2 million in benefits paid under the Child Immunization mandate, or .52% of total benefits. Benefit payments ranged from a low of .12% of benefits paid up to .2.69% of benefit paid. The ASO administrators did not report any excess benefit payments for child immunization, as defined under the mandate.

The Child Immunization mandate was a new mandate in 2001. Insurers and ASO plans were asked to provide the marginal cost data for this mandate. Marginal cost refers to the extra benefits that must be provided in order to bring their plans into compliance with the mandate. Most insurers and ASO services reported that they were already provided services equal to the mandate and, therefore, experienced no marginal cost increases. Two group health insurers did report a marginal cost of .194% and .442% of total benefits. Two individual health insurers reported a marginal cost of .112% and .292% of total benefits.

TMJ Disorders

Group health insurers reported $2.2 million in benefits paid under the TMJ mandate, or .06% of total benefits paid and .06% of total premium collected (see table on page 9). Benefit payments ranged from a low of .019% of benefits paid and .011% of premium collected to .18% of benefit paid and .17% of premium collected. Group health insurers reported paying $169,486 in excess benefits for TMJ Disorders

Individual health insurers reported $25,978 in benefits paid under the TMJ mandate, or .009% of total benefits paid and .007% of total premium collected. Benefit payments ranged from a low of .013% of benefits paid and .010% of premium collected to .09% of benefit paid and .09% of premium collected. Individual insurers did not report any excess benefit payments for TMJ Disorders.

Insurers with ASO business reported $583,810 in benefits paid under the TMJ mandate, or .52% of total benefits. Benefit payments ranged from a low of .12% of benefits paid up to

2.69% of benefit paid. The ASO administrators reported paying $24,989 in excess benefit payments for TMJ Disorders.

Summary of Results

	Average Cost as a % of Total Benefits		
Mandate	***Group***	***Individual***	***ASO***
Mental Health & AODA	3.23	N/A	3.12
Chiropractic Services	1.24	0.64	1.35
Diabetes	0.59	0.44	0.22
Child Immunizations	0.40	0.10	0.52
TMJ Disorders	0.06	0.009	0.06
Total	**5.53%**	**1.18%**	**5.26%**

	Total Benefits		
Mandate	***Group***	***Individual***	***ASO***
Mental Health & AODA	116,000,000	N/A	31,954,000
Chiropractic Services	44,804,800	1,833.4	13,787,700
Diabetes	21,229,000	1,250.3	2,263,700
Child Immunizations	14,558,000	293.2	5,278,900
TMJ Disorders	2,270,400	25.9	583,800

	Excess benefits paid		
Mandate	***Group***	***Individual***	***ASO***
Mental Health & AODA	4,440,100	N/A	6,183,900
Chiropractic Services	0	0	0
Diabetes	0	0	0
Child Immunizations	1,169,000	23,600	1,656,400
TMJ Disorders	169,400	0	24,900

CONCLUSIONS

1. The average cost of the five mandates included in the survey as a percentage of total benefits has decreased slightly since the previous surveys of activity in 1987-1990. This may be a result of the cost of health care services in general increasing more quickly than the cost of mandated benefits. In addition, prescription drug utilization and costs have been increasing more rapidly than other costs. Some insurers who responded to the survey indicated they did not include these costs in their response.

2. ASO contracts continue to provide benefits consistent with those provided by insured plans. This may be explained, in part, by the fact that only large employers are able to self-fund their health benefits and larger employers tend to offer more comprehensive benefits than small employers. An additional consideration is that the ASO contracts included in the survey are those administered by a licensed insurer. As a result of this

arrangement, they may develop benefit plans that are similar to those offered by these companies for their insured products which are required to provide the mandated benefits.

3. There is no way to determine from the data collected the extent to which the services provided through these mandated coverages are substitutes for other medical benefits included in an insurance policy.

4. The survey only considered five mandated benefits. Therefore, this data cannot be used to determine the total cost of mandated benefits.

Appendix A

Chiropractors

632.87(3)(a) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath, even if different nomenclature is used to describe the condition or complaint. Examination by or referral from a physician shall not be a condition precedent for receipt of chiropractic care under this paragraph. This paragraph does not:

632.87(3)(a)1 Prohibit the application of deductibles or coinsurance provisions to chiropractic and physician charges on an equal basis.

632.87(3)(a)2 Prohibit the application of cost containment or quality assurance measures to chiropractic services in a manner that is consistent with cost containment or quality assurance measures generally applicable to physician services and that is consistent with this section.

632.87(3)(b) No insurer, under a policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, may do any of the following:

632.87(3)(b)1 Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor.

632.87(3)(b)2 Refuse to provide coverage to an individual because that individual has been treated by a chiropractor.

632.87(3)(b)3 Establish underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers.

632.87(3)(b)4 Exclude or restrict health care coverage of a health condition solely because the condition may be treated by a chiropractor.

632.87(3)(c) An exclusion or a restriction that violates par. (b) is void in its entirety.

State of Wisconsin \ OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner
123 West Washington Avenue
P.O. Box 7873
Madison, Wisconsin 53707
(608) 266-3585

DATE: January 12, 1989

TO: Health Insurers Doing Business in Wisconsin

FROM: Robert D. Haase
Commissioner of Insurance

SUBJECT: Chiropractic Coverage Under Health Insurance Contracts Subject to Wisconsin Law

On October 9, 1987, OCI sent insurers a bulletin regarding the chiropractic mandate, s. 632.87, Wis. Stat. OCI continues to receive questions regarding this mandated coverage.

Attached is a copy of s. 632.87 (1) and (3), Wis. Stat., which mandates that services which are provided by a chiropractor be covered on the same basis as if such services were provided by a physician. This mandate became effective for all health insurance policies issued and renewed on or after January 1, 1988. All health insurance policies must provide such coverage by January 1, 1989. This includes group and individual policies, Medicare supplements, HMOs, and PPOs.

OCI is monitoring complaints received regarding coverage of chiropractic care and will pursue administrative action if there appears to be violations in contract language, underwriting, or claims procedures which appear to limit or discriminate against chiropractic treatment. Form filings will be carefully reviewed to ensure that the contract language is in compliance with the intent of s. 632.87 (3), Wis. Stat.

Insurers should review their policies' contract language, their underwriting procedures, and claim review processes to determine compliance with this mandate.

CONTRACT LANGUAGE

In order to clearly indicate how treatment by a chiropractor will be covered, the contract's definition of "physician" should specifically include chiropractors or should refer to medical practitioners, or practitioners of the healing arts, acting within the scope of their license.

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The covered charges listed in the policy should include treatment by chiropractors. Any exclusions related to chiropractic treatment must be deleted. Many insurers have submitted contract language which limits the number of chiropractic visits which will be covered or places a dollar maximum on treatment. Frequently, the limitations refer to subluxation of the spine or spinal manipulation. OCI will not approve such language as the intent is to limit treatment by chiropractors. Physicians typically will not provide this type of care. No limitations or copayments will be approved unless they apply equally to physician's visits.

In addition, OCI will not approve language which limits all treatment to the back, as some back injuries may require extensive treatment and such a limited benefit would be too restrictive to achieve the purposes for which the policy was sold.

The following are examples of contract language which have been disapproved by OCI:

-- Covered charges related to manipulative therapy, which includes the diagnosis and nonsurgical treatment of structural imbalance, distortion, dislocation, misplacement, or subluxation of vertebrae or the spinal column, will be limited to a maximum of $750 per calendar year.

-- The covered expense for treatments for the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column is limited to $20 for all treatment in any one day and shall not be payable for more than 20 visits in any one calendar year.

-- Outpatient services relating to the treatment of an illness or injury by means of spinal manipulation or other manipulative therapy. Coverage of these charges will be subject to the limitations on outpatient spinal manipulation or other manipulative therapy set forth in the section on general exclusions and limitations.

In all three cases, the language was disapproved because it specifically limited benefits for chiropractic care only, which violates s. 632.87, Wis. Stat.

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UNDERWRITING

Insurers should remember that ss. Ins 3.20 and 6.67, Wis. Adm. Code, prohibit declination of coverage or the exclusion of a condition from coverage, unless such a decision is based upon sufficient evidence, sound actuarial principles, or actual or reasonably anticipated experience. Insurers must conduct a proper investigation when processing an application so that underwriting action is taken prior to issuance of the policy and to avoid the practice of post-claim underwriting.

Insurers may not decline, limit, or rate-up coverage solely because an applicant has received chiropractic care. Medical records should be reviewed to determine the extent of the risk to be assumed, and the insurer must be able to substantiate, with documentation, any decision to decline, limit, or rate-up coverage.

CLAIMS

Insurers should use uniform standards for investigations of preexisting conditions. Chiropractic claims should be scrutinized with the same investigational procedures as with all claims.

An investigation of a claim regarding a preexisting condition must be in accordance with the contract language. For example, if a preexisting condition is defined as a sickness or injury for which treatment was received within one year prior to the effective date, the insurer should not review any medical documentation regarding treatment which was received prior to that time.

Chiropractic claims should be reviewed in accordance with guidelines and standards established by chiropractors associated with the insurer, such as a consultant or utilization review personnel. Chiropractic consultants should be used to review questionable claims or contested denials of claims, on a case-by-case basis, and coverage can be limited to treatment of an acute illness or injury.

Finally, insurers are reminded that chiropractic care may not be conditioned on a referral from a physician.

IF THERE ARE QUESTIONS REGARDING THE CHIROPRACTIC MANDATE, CONTACT BETH RITCHIE, BUREAU OF MARKET REGULATION, AT (608) 267-7322.

Thank you for your cooperation.

RDH:BCR:imk
Attachment
1224Q

Excerpt from June 24, 1992 Bulletin to All Insurers Authorized to Transact Business in Wisconsin. Signed by Robert D. Haase, Commissioner of Insurance

1991 WISCONSIN ACT 269 - BUDGET ADJUSTMENT BILL

1991 Wisconsin Act 269 (SB 483) includes the following provisions:

Chiropractic Coverage [s. 632.87, Wis. Stat.]

1. Stipulates that an insurer must apply cost-containment measures to chiropractic services in a manner consistent with those measures applied to physician services.

2. States that no insurer may restrict or terminate chiropractic coverage on the basis of an examination or evaluation other than by a chiropractor or peer review panel containing a chiropractor.

3. Prohibits an insurer from establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers.

4. Prohibits an insurer from refusing to provide coverage to an individual because the individual has been treated by a chiropractor.

5. Bars an insurer from excluding or restricting health care coverage of a health condition solely because the condition may be treated by a chiropractor.

These provisions apply to individual and group health insurance policies which are issued or renewed on or after **May 1, 1992.** Insurers should review their underwriting, utilization review, and claim settlement practices and make any revisions necessary to comply.

The State of Wisconsin
Office of the Commissioner of Insurance

Robert D. Haase
Commissioner
(608) 266-3585

DATE: OCTOBER 9, 1987

TO: HEALTH INSURERS DOING BUSINESS IN WISCONSIN

FROM: COMMISSIONER ROBERT D. HAASE

SUBJECT: CHIROPRACTIC COVERAGE UNDER HEALTH INSURANCE CONTRACTS SUBJECT TO WISCONSIN LAW

Attached is a copy of s. 632.87 (1) and (3), Wis. Stats., which mandates coverage for services provided by chiropractors.

INSURERS MUST REVIEW APPROVED POLICY FORMS AND DETERMINE IF CONTRACT PROVISIONS REQUIRE CHANGES TO MEET THE MINIMUM REQUIREMENTS OF THE LAW. POLICIES ISSUED ON OR AFTER JANUARY 1, 1988, MUST COMPLY WITH THE MANDATE.

This bulletin addresses the most frequently asked questions and is designed to assist insurers in drafting policy provisions which comply with the law. Insurers may comply with the law by filing an amended policy or a rider which can be attached to a previously approved policy.

1. **WHAT IS THE EFFECTIVE DATE?**

All health insurance policies issued ON OR AFTER JANUARY 1, 1988, must include coverage for chiropractic services if the policy covers treatment of the condition by a physician.

Policies issued BEFORE JANUARY 1, 1988, must include chiropractic coverage on the earliest of:

a) the date the insurer has the right to refuse to renew the policy

b) the date the insurer has the right to change the premium, or

c) January 1, 1989.

2. WHAT ARE THE MINIMUM REQUIREMENTS FOR APPROVAL OF POLICY LANGUAGE?

The minimum requirement for many policies will be removal of exclusions for treatment provided by chiropractors. Insurers will need to review each policy form to determine if additional changes are required. Some examples, based on forms submitted to date, are discussed below:

a) EXCLUSIONS--No policy may contain an exclusion for care provided by a chiropractor. All such exclusions must be deleted from policies.

b) LIMITATIONS--No policy may contain limitations on chiropractic services which do not apply equally to physicians' services. Examples might be special deductibles, limits on the number of visits, or lifetime maximums.

c) REFERRALS--No policy may contain a provision requiring a policyholder to obtain a referral from a physician before seeking treatment from a chiropractor.

d) DEFINITIONS--No policy may contain definitions which restrict coverage to physicians. For example, definitions of physician and medical necessity may not be worded so that their effect would exclude chiropractic coverage.

3. MAY CLOSED PANEL PLANS SUCH AS HMOs AND PPOs REQUIRE THAT ENROLLEES OBTAIN REFERRALS FROM THEIR PRIMARY CARE PROVIDER FOR CHIROPRACTIC SERVICES?

No. Contract provisions requiring that the enrollee obtain a referral from a primary care provider who is a physician must be modified to make it clear that referral from a physician is not required for chiropractic care.

4. MUST HMOs AND PPOs ALLOW CHIROPRACTORS TO BE PRIMARY CARE PROVIDERS?

No. There is no requirement that chiropractors be included as primary care providers.

5. MAY CLOSED PANEL PLANS REQUIRE THAT POLICYHOLDERS USE CHIROPRACTORS WHO HAVE AGREED TO PARTICIPATE AS PLAN PROVIDERS?

Yes. Closed panel plans may contract with selected chiropractors.

6. IS THERE A REQUIREMENT AS TO THE NUMBER OF CHIROPRACTORS CLOSED PANEL PLANS SUCH AS HMOs AND PPOs MUST HAVE AVAILABLE TO ENROLLEES?

No. Each insurer must have sufficient numbers of chiropractic providers to meet the demand.

7. **MUST MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT POLICIES PROVIDE COVERAGE FOR CHIROPRACTIC SERVICES?**

Yes. Medicare supplement and medicare replacement policies are subject to s. 632.87 (1) and (3), Wis. Stats., and must provide the scope of coverage required. These policies may not limit coverage to the chiropractic services covered under the Medicare program.

8. **WHAT STEPS CAN AN INSURER TAKE TO ENSURE APPROVAL OF POLICY FORM AMENDMENTS?**

Approved policy forms which must be amended to comply with s. 632.87, Wis. Stats., will receive expedited review if the following steps are followed:

a) The form filing is limited to amendments to comply with the chiropractic mandate,

b) The form filing includes a properly completed policy form transmittal (OCI form 26-15) and certificate of compliance; and

c) The cover letter includes a request for expedited review of the chiropractic amendments.

OCI staff will review the forms within 10 days of receipt if the steps listed above are followed.

THIS BULLETIN IS A BRIEF SUMMARY OF THE CHIROPRACTIC MANDATE. IF THERE ARE QUESTIONS, CONTACT SUSAN ABDEL-MONEIM, BUREAU OF MARKET REGULATION AT (608) 266-8885.

SAM:bh
338Q

October 9, 1987
Page Four

632.87 (1) No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that the services were not rendered by a physician as defined in s. 990.01 (28), unless the contract clearly excludes services by such practitioners, but no contract or plan may exclude services in violation of subs. (2m) and (3).

632.87 (3) (a) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath, even if different nomenclature is used to describe the condition or complaint. Examination by or referral from a physician shall not be a condition precedent for receipt of chiropractic care under this paragraph. This paragraph does not:

1. Prohibit the application of deductibles or coinsurance provisions to chiropractic and physician charges on an equal basis.

2. Prohibit the application of cost containment or quality assurance measures in a manner consistent with this section.

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Appendix B

Nervous and Mental Disorders, Alcoholism, and Other Drug Abuse-

632.89 Required coverage of alcoholism and other diseases.
632.89 **(1) Definitions.** In this section:

632.89(1)(a) "Collateral" means a member of an insured's immediate family, as defined in s. 632.895 (1).

632.89(1)(c) "Hospital" means any of the following:

632.89(1)(c)1. A hospital licensed s. 50.35.

632.89(1)(c)2. An approved private treatment facility as defined s. 51.45 (2) (b).

632.89(1)(c)3. An approved public treatment facility as defined in s. 51.45 (2) (c).

632.89(1)(d) "Inpatient hospital services" means services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are provided in a hospital to a bed patient in the hospital.

632.89(1)(e) "Outpatient services" means nonresidential services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems provided to an insured and, if for the purpose of enhancing the treatment of the insured, a collateral by any of the following:

632.89(1)(e)1. A program in an outpatient treatment facility, if both are approved by the department of health and family services, the program is established and maintained according to rules promulgated s. 51.42 (7) (b) and the facility is certified under s. 51.04.

632.89(1)(e)2. A licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office.

632.89(1)(e)3. A licensed psychologist who is listed in the national register of health service providers in psychology or who is certified by the American board of professional psychology.

632.89(1)(em) "Policy year" means any period of time as defined by the group or blanket disability insurance policy that does not exceed 12 consecutive months.

632.89(1)(f) "Transitional treatment arrangements" means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, and that are specified by the commissioner by rule under sub. (4).

632.89(2) Required coverage.

632.89(2)(a) *Conditions covered.*

632.89(2)(a)1. A group or blanket disability insurance policy issued by an insurer shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if required by and as provided in pars. (b) to (e).

632.89(2)(a)2. Except as provided pars. (b) to (e), coverage of conditions subd. 1. by a policy may be subject to exclusions or limitations, including deductibles and copayments, that are generally applicable to other conditions covered under the policy.

632.89(2)(b) *Minimum coverage of inpatient hospital, outpatient and transitional treatment arrangements.*

632.89(2)(b)1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in every policy year as provided pars. (c) to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed $7,000 or the equivalent benefits measured in services rendered.

632.89(2)(b)2. The amount under subd. 1. may be reduced if the policy is written in combination with major medical coverage to the extent that results in combined coverage complying with subd. 1.

632.89(2)(c) *Minimum coverage of inpatient hospital services.*

632.89(2)(c)1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any inpatient hospital treatment, the policy shall provide coverage for inpatient hospital services for the treatment of conditions under par. (a) 1. as provided in subd. 2.

632.89(2)(c)2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than the lesser of the following:

632.89(2)(c)2.a. The expenses of 30 days as an inpatient in a hospital.

632.89(2)(c)2.b. Seven thousand dollars minus any applicable cost sharing at the level charged under the policy for inpatient hospital services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, $6,300 in equivalent benefits measured in services rendered.

632.89(2)(d) *Minimum coverage of outpatient services.*

632.89(2)(d)1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any outpatient treatment, the policy shall provide coverage for outpatient services for the treatment of conditions under par. (a) 1. as provided in subd. 2.

632.89(2)(d)2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than $2,000 minus any applicable cost sharing at the level charged under the policy for outpatient services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, $1,800 in equivalent benefits measured in services rendered.

632.89(2)(dm) *Minimum coverage of transitional treatment arrangements.*

632.89(2)(dm)1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any inpatient hospital treatment or any outpatient treatment, the policy shall provide coverage for transitional treatment arrangements for the treatment of conditions under par. (a) 1. as provided in subd. 2.

632.89(2)(dm)2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than $3,000 minus any applicable cost sharing at the level charged under the policy for transitional treatment arrangements or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, $2,700 in equivalent benefits measured in services rendered.

632.89(2)(e) *Exclusion.* This subsection does not apply to a health care plan offered by a limited service health organization, as defined in s. 609.01 (3).

632.89(2m) Liability to the state or county. For any insurance policy issued on or after January 1, 1981, any insurer providing hospital treatment coverage is liable to the state or county for any costs incurred for services an inpatient health care facility, as defined in s. 50.135 (1), or community-based residential facility, as defined in s. 50.01 (1g), owned or operated by a state or county, provides to a patient regardless of the patient's liability for the services, to the extent that the insurer is liable to the patient for services provided at any other inpatient health care facility or community-based residential facility.

632.89(3m) Issuance of policy. Every group or blanket disability insurance policy subject to sub. (2) shall include a definition of "policy year".

632.89(4) Specify transitional treatment arrangements by rule. The commissioner shall specify by rule the services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, including but not limited to day hospitalization, that are covered under sub. (2) (dm).

632.89(5) Medicare exclusion. No insurer or other organization subject to this section is required to duplicate coverage available under the federal medicare program.

State of Wisconsin
Office of the Commissioner of Insurance

Bulletins to Insurers

Date: April 28, 1998
To: All Health Insurers Licensed in Wisconsin
From: Randy Blumer, Commissioner of Insurance
Subject: Mental Health Parity

The federal Mental Health Parity Act (MHPA) became effective January 1, 1998, with health plans given until April 1, 1998, to comply with its requirements. Many insurers have reported difficulty in complying with both the state mental health and AODA services mandate and federal mental health parity act requirements.

Under MHPA, insurance plans that cover mental health services are not permitted to establish dollar-based annual or lifetime maximums for mental health services that are different than for other covered medical services. Limits on the number of visits or treatment days are permitted. Only mental health services are affected; AODA services are specifically exempted from MHPA. State law (s. 632.89, Wis. Stat.) requires all group or blanket disability insurance plans to cover a minimum of $7,000 (subject to 10% coinsurance) in mental health and AODA services annually. Only HMOs are permitted to substitute an actuarial value of the MH/AODA benefit in visits or days. This bulletin addresses the apparent conflict between state minimums, required to be expressed in dollars, and federal law, prohibiting dollar limits on mental health services.

Based on our discussions with the federal Health Care Financing Administration (HCFA), OCI has determined that policies that outline the minimum mental health benefit, stated in dollars, in accordance with Wisconsin law and that have any maximum benefit in the policy stated according to federal law would meet the requirements of both agencies. Policy forms, except for HMO forms, must express the minimum coverage required by the State mandate in dollars. Any HMO policy forms submitted to OCI that limit mental health benefits to days or visits must include an actuarial certification documenting that the required state minimum benefit, expressed in dollars, is available to policyholders.

Questions regarding this bulletin may be addressed to:

Barbara Belling, Health and Life Section, Market Regulation Bureau at barbara.belling@oci.state.wi.us.

Insurers with questions regarding MHPA should contact Don Hankey in the HCFA Chicago Regional Office at 312-353-8170.

Updated: May 4, 1998

Excerpt from October 24, 1997 Bulletin to All Insurers Authorized to Write Insurance in Wisconsin. Signed by Josephine W. Musser, Commissioner of Insurance

MANDATED BENEFITS

Mental Health and AODA Services - s. 632.89(2) (a) 2, Wis. Stat.

Changed the mandate to allow claims for mental health and AODA services to be subject to deductibles that are generally applicable to other conditions covered under the policy.

Effective date - Group or blanket health insurance policies that are issued or renewed on or after March 1, 1998. There is an exception for policies issued pursuant to a collective bargaining agreement; the change applies to the earlier of the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified or renewed.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Robert D. Haase
Commissioner

121 East Wilson Street
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

DATE: October 26, 1992

TO: Insurers Authorized to Write Disability and Health Insurance in Wisconsin

FROM: Robert D. Haase
Commissioner of Insurance

SUBJECT: Emergency Rule on Transitional Treatment Arrangements

1991 Wisconsin Act 250 required that the Commissioner of Insurance promulgate administrative rules specifying the transitional treatment arrangements which are eligible for benefits under s. 632.89 (2) (b) 1. (dm) and (4), Wis. Stat. A public hearing on the proposed rule was held on August 27, 1992. After considering oral and written comments, the Commissioner revised the rule which was effective September 29, 1992, on an emergency basis. All group and blanket health insurance policies issued or renewed on and after November 1, 1992, are required to comply with s. Ins 3.37, Wis. Adm. Code, a copy of which is enclosed.

INSURERS MUST REVISE POLICY FORMS TO INCLUDE COVERAGE FOR TRANSITIONAL TREATMENT ARRANGEMENTS. INSURERS SHOULD REVIEW EXISTING POLICY LANGUAGE AND SUBMIT REVISIONS AS SOON AS POSSIBLE. Policy forms review will look for the following points:

BENEFIT DESCRIPTION

Indemnity policies--coverage for the first $3,000 of transitional treatment services. A 10% coinsurance provision is permitted so that the policy pays out $2,700 per policy year.

HMO policies--Coverage for the first $2,700 of transitional treatment services per policy year. No copayments or coinsurance provisions are permitted.

Each insurer must list the six types of service providers listed in s. Ins 3.37 (3), Wis. Adm. Code, in their policies and certificates.

TYPES OF SERVICES COVERED

1. Adult day treatment certified under s. HSS 61.75.

2. Child and adolescent day treatment certified under s. HSS 61.81.

3. Services for chronically mentally ill persons provided through a community support program certified under s. HSS 63.03.

4. Services in residential treatment programs for alcohol and drug dependent persons certified under s. HSS 61.60.

5. Services for alcoholism and other drug problems in a day treatment program certified under s. HSS 61.61.

6. Services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine (ASAM), is a clinical guide used for matching patients to appropriate levels of care.

DETERMINATION OF COVERAGE

Insurers must also include a description of methods used to evaluate claims for transitional treatment services to determine medical necessity and eligibility for benefits under the policy.

FURTHER INFORMATION

Information on certified providers can be obtained from Dan Crossman, Program Support Section, Division of Community Services, 1 West Wilson, Room 543, P. O. Box 7851, Madison, Wisconsin 53707, (608) 266-0120.

Information on the ASAM criteria can be obtained from the American Society of Addiction Medicine, 5225 Wisconsin Avenue, N.W., Suite 409, Washington, DC 20015, (202) 244-8948.

If you have questions, please put them in writing and address them to Susan Ezalarab, Chief, Health and Life Insurance, Office of the Commissioner of Insurance, P. O. Box 7873, Madison, Wisconsin 53707.

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Enclosure
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ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE
CREATING AN EMERGENCY RULE

To create s. Ins 3.37, relating to specifying the transitional treatment services for nervous or mental diseases or alcoholism or other drug abuse problems that health insurance must cover.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 632.89 (4), Stats.

Statutes interpreted: s. 632.89 (1) (f) and (2) (dm), Stats.

1991 Wisconsin Act 250, which took effect May 12, 1992, requires group and blanket disability insurance policies that provide coverage for any inpatient hospital treatment or any outpatient treatment to also provide coverage for transitional treatment arrangements for nervous or mental disorders or alcoholism or other drug abuse (AODA). Transitional treatment arrangements are described by statute as services provided to an insured in a less restrictive manner than inpatient hospital services but in a more intensive manner than are outpatient services. The commissioner of insurance (commissioner) is required to specify the covered services by rule.

This rule was drafted after receiving comments from department of health and social services staff, mental health and AODA service providers, health insurers and community organizations.

This emergency rule requires that a policy subject to this rule provide at least the amount of coverage required by the statute ($2,700, or the equivalent amount in services provided by a health maintenance organization) for services provided for the treatment of AODA in a day treatment or residential treatment program certified by the department of health and social services (DHSS). Day treatment programs, which are operated by certified inpatient and outpatient AODA facilities, are nonresidential programs that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week. The statute requires these day treatment programs, also known as partial hospitalization, to be included in the rule. Residential treatment programs are therapeutic programs for alcohol and drug dependent persons. They include therapeutic communities and transitional facilities.

The rule also requires coverage for intensive outpatient programs for the treatment of psychoactive substance use disorders provided by specialists in addiction medicine according to the patient placement criteria of the American society of addiction medicine.

Insurers must provide coverage for mental health day treatment or day hospital programs for adults and mental health services for children and adolescents offered by day treatment programs certified by DHSS. Coverage must also be available for the mental health services provided in community support programs offered by county departments of community programs throughout the state. These programs offer a variety of services to persons with chronic mental illnesses which by history or prognosis require repeated acute treatment or prolonged periods of institutional care.

An insurer may meet the coverage requirements by covering substantially similar services and programs in another state, if the provider is in compliance with that state's requirements.

Each insurer must include in its policy form the types of transitional treatment programs which are covered (those specified in the rule) and a description of the method used to evaluate transitional treatment programs or services to determine medical necessity and eligibility for coverage under the policy.

The commissioner intends to continue to consult with the department of health and social services staff as they develop and revise certification procedures for mental health and AODA programs and to revise the rule as necessary to expand covered services as new programs which meet the definition of transitional treatment arrangements are certified.

FINDING OF EMERGENCY

The mandated coverage for transitional treatment arrangements applies to health insurance policies issued or renewed on and after November 1, 1992. This emergency rule and also the permanent rule specifying the programs and services that must be covered have had a public hearing and the permanent rule (Clearinghouse Rule No. 92-132) has been submitted for legislative review. However, the review process will not be completed in time for the permanent rule to take effect before the mandate does. Without the rule, insurers and treatment providers will be unable to determine what transitional services are covered under health insurance policies.

The commissioner of insurance therefore finds that an emergency exists and that the promulgation of this emergency rule is necessary for the immediate preservation of the public peace, health, safety or welfare.

SECTION 1. Ins 3.37 is created to read:

Ins 3.37 TRANSITIONAL TREATMENT ARRANGEMENTS. (1) PURPOSE. This section implements s. 632.89 (4), Stats.

(2) APPLICABILITY. This section applies to group and blanket disability insurance policies issued or renewed on and after November 1, 1992, that provide coverage for inpatient hospital services or outpatient services, as defined in s. 632.89 (1) (d) or (e), Stats.

(3) COVERED SERVICES. A policy subject to this section shall provide at least the amount of coverage required under s. 632.89 (2) (dm) 2., Stats., for all of the following:

(a) Mental health services for adults in a day treatment program offered by a provider certified by the department of health and social services under s. HSS 61.75.

(b) Mental health services for children and adolescents in a day treatment program offered by a provider certified by the department of health and social services under s. HSS 61.81.

(c) Services for persons with chronic mental illness provided through a community support program certified by the department of health and social services under s. HSS 63.03.

(d) Residential treatment programs for alcohol or drug dependent persons or both certified by the department of health and social services under s. HSS 61.60.

(e) Services for alcoholism and other drug problems provided in a day treatment program certified by the department of health and social services under s. HSS 61.61.

(f) Intensive outpatient programs for the treatment of psychoactive substance use disorders provided in accordance with the patient placement criteria of the American society of addiction medicine.

(4) OUT-OF-STATE SERVICES AND PROGRAMS. An insurer may comply with sub. (3) (a) to (e) by providing coverage for services and programs that are substantially similar to those specified in sub. (3) (a) to (e), if the provider is in compliance with similar requirements of the state in which the provider is located.

(5) POLICY FORM REQUIREMENTS. An insurer shall specify in each policy form all of the following:

(a) The types of transitional treatment programs and services covered by the policy as specified in sub. (3).

(b) The method the insurer uses to evaluate a transitional treatment program or service to determine if it is medically necessary and covered under the terms of the policy.

SECTION 2. INITIAL APPLICABILITY. This rule first applies to group and blanket disability policies subject to s. 632.89, Stats., issued or renewed on and after November 1, 1992.

SECTION 3. EFFECTIVE DATE. This rule will take effect on publication, as provided in s. 227.24 (1) (c), Stats.

Dated at Madison, Wisconsin, this 24 day of Sept 1992

/s/

John W. Torgerson
Deputy Commissioner of Insurance

Excerpt from May 19, 1992 Bulletin to Insurers Authorized to Write Disability Insurance in Wisconsin. Signed by Robert D. Haase, Commissioner of Insurance

CHANGES TO ALCOHOLISM AND OTHER DRUG ABUSE (AODA) MANDATE

Sections 632.89 (2) (b) 1, (dm) and (4), Wis. Stat., require that group health insurance contracts provide coverage for transitional AODA treatment arrangements, such as day hospitalization, which will be specified by a rule to be drafted by OCI. The required amount of coverage is $3,000 less a 10% copayment, or the first $2,700 of benefits provided by a health maintenance organization (HMO). The effective date is November 1, 1992.

Section 632.89 (2) (d) 2, Wis. Stat., increases the minimum coverage for outpatient treatment from $1,000 to $2,000 less a copayment of up to 10%, or the first $1,800 for HMO plans. The increased amount of coverage applies to policies and certificates issued or renewed on and after May 12, 1992.

The maximum an insurer is required to cover remains at $7,000 per policy year.

Excerpt from June 17, 1988 Bulletin to Health and Life Insurers Doing Business in Wisconsin. Signed by Robert D. Haase, Commissioner of Insurance

Section 632.89, Wis. Stat., requires insurers to define "policy year" as any period of time not exceeding 12 consecutive months. To ease claims administration, insurers can equate "policy year" with calendar year.

Insurers should review group health policy forms and submit amendments defining policy year to the Commissioner for approval.

The statute does not apply to individual policies and policies offering limited coverage, such as those offered by limited service health organizations.

This bulletin is a brief summary of the changes in Wisconsin insurance law. Questions should be referred to Bureau of Market Regulation.

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06/08/88

The State of Wisconsin
Office of the Commissioner of Insurance

Thomas P. Fox
Commissioner
(608) 266-3585

DATE: July 26, 1985

TO: Chief Executive Officers
Health Insurers

FROM: Thomas P. Fox TPF
Commissioner of Insurance

SUBJECT: Mandated Benefits for the Treatment of Nervous and Mental Disorders, Alcoholism and Drug Abuse

The 1985 - 1987 Wisconsin biennial budget, 1985 Wisconsin Act 29, contained a provision changing and increasing the mandated benefits for inpatient and outpatient treatment of nervous and mental disorders, alcoholism and drug abuse. Those changes became effective July 20, 1985, and apply to all group disability policies, joint contracts or other contracts issued or renewed on or after that date which provide coverage of inpatient hospital services or inpatient hospital and outpatient services combined. A detailed list of the new mandates is enclosed.

The increases in benefits do not apply to existing policies until such time as those policies renew. We interpret a group policy to be renewed on any date specified in the policy as a renewal date, on any date on which the insurer or the insured changes the rate of premium for the group policy, the date on which the underlying collective bargaining agreement or other underlying contract is renewed, or any date on which a significant change is made in benefits.

It will be necessary for all insurers to submit group policy forms containing the new benefits for approval. We expect that all insurers will take whatever steps are necessary to expeditiously submit the revised forms for approval. Likewise, my staff will review the forms as quickly as possible.

I recognize that some time delays, however, will occur before all policies are approved. I also recognize that it is unrealistic and not in the public interest to expect that insurers will not issue or renew policies until such time as the policies contain wording to show the new benefits and have been approved by this office.

Therefore, it will be permissible for insurers to continue to issue and renew currently approved policies provided that the following three steps are taken:

1. Revised policy forms are submitted to OCI for approval as quickly as possible;

2. Claims for nervous and mental disorders, alcoholism and drug abuse are administered according to the newly enacted provisions expanding the benefits; and

3. Policyholders and subscribers are advised in writing of the increased benefits by August 15, 1985.

Steps 1, 2 and 3 above apply ONLY to the increases in mandated benefits. The budget bill's provision applying to permissive copayments for outpatient services must have prior form approval from this office before being applied.

In the event that the premium will increase at the time of renewal because of the increased benefits, s. 631.36, Wis. Stats., requires an insurer to provide notice to the policyholder 30 days prior to the expiration date. The notice cannot be given on a retroactive basis for the groups which have renewed since July 20. However, commencing with receipt of this memo, we expect all insurers to notify policyholders of the renewal terms and to give 30 days notice for policies which will renew 30 or more days in the future. For policies renewing between now and 30 days hence, insurers should give as much notice as is possible to do.

Health maintenance organizations and limited service health organizations can provide the additional mandated benefits in one of two ways -- either as a set dollar amount or as equivalent benefits measured in services rendered. HMOs and LSHOs using the latter method must disclose in writing to policyholders and members how the equivalent benefits are determined. The permissive copayment provisions for outpatient services referred to above applies only to fee-for-service plans and does not apply to plans offered by an HMO or LSHO.

If you have any questions regarding this, please contact Susan Abdel-Moneim (266-8885) or Sandy Drew Anderson (266-7649).

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1985-1987 BIENNIAL BUDGET AMENDMENTS TO s. 632.89
MANDATED BENEFITS FOR THE TREATMENT OF NERVOUS AND
MENTAL DISORDERS, ALCOHOLISM AND DRUG ABUSE

(1) All of the current s. 632.89 (1) and (2) are repealed and recreated.

(2) All group disability contracts or policies which provide coverage for inpatient hospital services and outpatient services shall provide:

(a) minimum coverage of inpatient hospital services and

(b) minimum coverage of outpatient services.

The combined coverage for both inpatient hospital and outpatient services need not exceed $7,000 or equivalent benefits measured in services for HMOs and LSHOs. This amount may be reduced if the policy is written in combination with major medical coverage to the extent that the combined coverage results in complying with the above requirements.

(3) If a group disability policy provides coverage of any inpatient hospital treatment, it shall provide coverage for not less than the lesser of:

(a) expenses for the first 30 days as an inpatient;

(b) the first $7,000 minus a copayment of up to 10% for fee-for-service plans or the first $6,300 or equivalent benefits measured in services for HMOs or LSHOs; or

(c) the difference between $7,000 and the benefits paid for outpatient services.

(4) If a group disability policy provides coverage for any outpatient treatment, it shall provide coverage for not less than the lesser of:

(a) the first $1,000 of outpatient services minus a copayment of up to 10% for fee-for-service plans;

(b) the first $900 or the equivalent benefits measured in services for HMOs or LSHOs; or

(c) the difference between $7,000 and the benefits paid for inpatient hospital services.

(5) All benefits shall be provided on a policy year basis rather than on a calendar year.

(6) Nervous and mental disorders, alcoholism and drug abuse may not be subject to exclusions or limitations that do not generally apply to other covered conditions.

(7) Outpatient services cover a "collateral" who seeks the services to enhance the treatment of the insured. A "collateral" means a member of an insured's immediate family and is limited to the spouse, children, parents, grandparents, brothers and sisters of the insured and their spouses.

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(8) Inpatient hospital services must be provided in a hospital to a bed patient in the hospital.

(9) A "hospital" is defined as:

(a) A hospital licensed under s. 50.35 which is devoted primarily to the diagnosis, treatment of, and medical or surgical care for three or more nonrelated individuals who suffer from illness, disease, injury, etc.

(b) An approved public treatment facility which is a treatment agency that operates under the direction and control of DHSS or provides treatment for nervous and mental disorders, alcoholism or drug abuse either through a contract with DHSS or the local county mental health board. The facility must meet the standards established by DHSS and must be approved by DHSS.

(c) An approved private treatment facility is one which meets the standards established by DHSS and is approved by DHSS. The only difference between it and a public treatment facility is that the private treatment facility does not have a contract with DHSS or the local county mental health board.

(10) "Outpatient services" mean nonresidential services provided to an insured or a collateral by any of the following:

(a) A program in an outpatient treatment facility if approved by DHSS and if established and maintained according to the rules promulgated by DHSS.

(b) A licensed physician who has completed a residency in psychiatry.

(c) A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology.

(11) In order to be listed in the National Register of Health Service Providers in Psychology, a psychologist must:

(a) Be currently licensed by the Psychology Examining Board at the independent level of psychology,

(b) Have a doctoral degree in psychology from an accredited institution, and

(c) Have two years of supervised experience in health service in psychology of which at least one year is in an organized health service training program and one year in post doctoral.

(12) DHSS is required every three years to review the coverage amounts and to recommend increases to the governor reflecting growth rates. However, the growth rate may not be greater than that spent by the state for medical assistance.

(13) The "Additional required coverage for corporations subject to ch. 613" sunsets on July 1, 1987.

(14) The above changes took effect on July 20, 1985, and apply to all policies which are issued or renewed after that date.

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Appendix C

Diabetes

632.895(6) Equipment and supplies for treatment of diabetes. Every disability insurance policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self-management education programs. Coverage required under this subsection shall be subject to the same exclusions, limitations, deductibles, and coinsurance provisions of the policy as other covered expenses, except that insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

State of Wisconsin
Office of the Commissioner of Insurance

Bulletins to Insurers

Date: October 16, 2002
To: All Insurers Licensed to Transact the Business of Health Insurance in Wisconsin
From: Connie L. O'Connell, Commissioner of Insurance
Subject: Equipment and Supplies for the Treatment of Diabetes, s. 632.895(6), Wis. Stat.

2001 Wisconsin Act 82 amended s. 632.895(6) to include prescription drugs for the treatment of diabetes. In addition, the words "exclusions" and "limitations" were added to the second sentence of the statute. The amendments become generally effective on January 1, 2003. The current statute reads, in part, as follows. The amended language is in bold:

> 632.895 (6) Equipment and Supplies For Treatment of Diabetes.
> Every disability insurance policy which provides coverage of expenses incurred for treatment of diabetes shall provide coverage for expenses incurred by the installation and use of an insulin infusion pump, coverage for all other equipment and supplies, including insulin **or any other prescription medication,** used in the treatment of diabetes, and coverage of diabetic self-management education programs. Coverage required under this subsection shall be subject to the same **exclusions, limitations,** deductibles, and coinsurance provisions of the policy as other covered expenses, except that . . .

The office has received a number of questions concerning the effect of this amendment on the coverage for prescription drugs for the treatment of diabetes. In particular, a question was raised about how this amendment will affect the coverage for prescription drugs for the treatment of diabetes under a Medicare supplement insurance policy. Since Medicare supplement insurance policies provide coverage for the treatment of diabetes, they will be required to provide coverage for prescription drugs for the treatment of diabetes. However, they may apply the same deductibles and coinsurance to these prescription drugs as they apply to prescription drugs under the policies in general. This means that, for those Medicare supplement policies that do not have a prescription drug rider, prescription drugs for the treatment of diabetes would be counted toward the $6,250 prescription drug deductible contained in the core benefit package with 80/20 coinsurance thereafter. For those Medicare supplement policies that have a prescription drug rider, the deductibles, coinsurance and coverage limitations in the rider would apply to the prescription drug coverage for the treatment of diabetes.

For non-Medicare supplement policies, the same deductibles, coinsurance amounts and limitations that apply to the policy's prescription drug coverage, if the policy covers prescription drugs, also apply to the prescription drug coverage for the treatment of diabetes. If the policy provides coverage for the treatment of diabetes, but does not cover prescription drugs, the policy must still cover prescription drugs for the treatment of diabetes. It may apply the deductible, coinsurance and coverage limitations that apply generally to other covered expenses. If the policy does not provide coverage for the

treatment of diabetes, then it is not required to provide coverage for prescription drugs for the treatment of diabetes.

Any questions concerning this bulletin may be directed to Diane Dambach, Chief, Accident and Health Section at diane.dambach@oci.state.wi.us.

Thank you.

Updated: October 16, 2002

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Excerpt from June 17, 1988 Bulletin to Health and Life Insurers Doing Business in Wisconsin. Signed by Robert D. Haase, Commissioner of Insurance

Section 632.895 (6), Wis. Stat., has been amended to require every disability policy providing coverage of expenses incurred for the treatment of diabetes to provide coverage for an insulin infusion pump or other equipment or supplies, including insulin. Insulin is a "supply" under the statute and must be covered under these policies.

Policy form filings which include exclusions for drugs or for insulin must be amended to include a positive statement that insulin is a covered benefit under the policy.

Appendix D

TMJ Disorders

632.895(11) Treatment for the correction of temporomandibular disorders.
632.895(11)(a) Except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, village, town or school district, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

632.895(11)(a)1. The condition is caused by congenital, developmental or acquired deformity, disease or injury.

632.895(11)(a)2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

632.895(11)(a)3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

632.895(11(b)
632.895(11)(b)1. The coverage required under this subsection for nonsurgical treatment includes coverage for prescribed intraoral splint therapy devices.

632.895(11)(b)2. The coverage required under this subsection does not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

632.895(11)(c)
632.895(11)(c)1. The coverage required under this subsection may be subject to any limitations, exclusions or cost-sharing provisions that apply generally under the disability insurance policy or self-insured health plan.

632.895(11)(c)2. Notwithstanding subd. 1., the coverage required under this subsection for diagnostic procedures and medically necessary nonsurgical treatment for the correction of temporomandibular disorders may not exceed $1,250 annually.

632.895(11)(d) Notwithstanding par. (c) 1., an insurer or a self-insured health plan of the state or a county, city, village, town or school district may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

632.895(11)(e) This subsection does not apply to any of the following:

632.895(11)(e)1. A disability insurance policy that covers only dental care.

632.895(11)(e)2. A medicare supplement policy, as defined in s. 600.03 (28r).

Excerpt from June 19, 1998 Bulletin to All Insurers Licensed in Wisconsin. Signed by Randy Blumer, Commissioner of Insurance

TMJ Mandate - s. 632.895 (11) and (12), Wis. Stat.
The TMJ mandate is amended to cap coverage of non-surgical diagnosis and treatment of TMJ at $1250 per year. Dental-only and medicare supplement policies are exempt from the mandate and dental plans are also now exempt from the anesthesia coverage requirement. Plans are now permitted to impose a prior authorization requirement on surgical or non-surgical TMJ services, but not diagnosis.
Effective Date: Policies issued or renewed on or after June 17, 1998.

Excerpt from October 24, 1997 Bulletin to All Insurers Authorized to Write Insurance in Wisconsin. Signed by Josephine W. Musser, Commissioner of Insurance

TMJ Coverage - ss. 609.78 and 632.895 (11), Wis. Stat.

Requires every group and individual disability insurance policy including HMOs, PPPs, and LSHOs and every self-insured county, municipality and school district health plan that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue, to provide coverage for diagnostic procedures and medically necessary surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular(TMJ) disorders.

Effective date - Health insurance policies that are issued or renewed on or after January 1, 1998. There is an exception for policies issued pursuant to a collective bargaining agreement; the change applies to the earlier of the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified or renewed.

Appendix E

Child Immunizations

632.895(14) Coverage of immunizations.
632.895(14)(a) In this subsection:

632.895(14)(a)1. "Appropriate and necessary immunizations" means the administration of vaccine that meets the standards approved by the U.S. public health service for such biological products against at least all of the following:

632.895(14)(a)1a. Diphtheria.

632.895(14)(a)1.. Pertussis.

632.895(14)(a)1.c. Tetanus.

632.895(14)(a)1.d. Polio.

632.895(14)(a)1.e. Measles.

632.895(14)(a)1.f. Mumps.

632.895(14)(a)1.g. Rubella.

632.895(14)(a)1.h. Hemophilus influenza B.

632.895(14)(a)1.i. Hepatitis B.

632.895(14)(a)1.j. Varicella.

632.895(14)(a)2. "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full-time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

632.895(14)(b) Except as provided in par. (d), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village or school district, that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

632.895(14)(c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.

632.895(14)(d) This subsection does not apply to any of the following:

632.895(14)(d)1. A disability insurance policy that covers only certain specified diseases.

632.895(14)(d)2. A disability insurance policy that covers only hospital and surgical charges.

632.895(14)(d)3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

632.895(14)(d)4. A long-term care insurance policy, as defined s. 600.03 (28g).

632.895(14)(d)5. A medicare replacement policy, as defined in s. 600.03 (28p).

632.895(14)(d)6. A medicare supplement policy, as defined in s. 600.03 (28r).

Excerpt from June 23, 2000 Bulletin to All Insurers Authorized to Write Insurance in Wisconsin. Signed by Connie L. O'Connell, Commissioner of Insurance

Act 115 - Immunizations for Children

This act creates s. 632.895 (14), Wis. Stat., and requires every disability insurance policy (with some exceptions) and every self-insured health plan of the state or a county, city town, village or school district, that provides coverage for a dependent of an insured, to provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments or coinsurance under the policy or plan.
Act 115 is effective for disability insurance policies that are issued or renewed on or after November 1, 2000.